		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044487

Facility Name: Greenbrier Lodge

Address: 600 South Maple (Number) Piper City (City) 60959 (Zip Code)

County: Iroquois

Telephone Number: 815-686-2277 **Fax #** 815-686-2812

IDPA ID Number: 370920203

Date of Initial License for Current Owners: 06/01/2001

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Teresa Thompson **Telephone Number:** (815) 686-2277

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/2003 to 10/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Teresa Thompson, RN
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Michael Stroud, Smith, Koelling, Dykstra & Ohm, P.C.
(Firm Name & Address) 1605 N. Convent, Bourbonnais, IL 60914
(Telephone) (815) 937-1997 Fax # (815) 935-0360

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,960	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,126	1,252	2,870	5,248	8
9	SNF/PED					9
10	ICF	8,862	6,396	2	15,260	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,988	7,648	2,872	20,508	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.39%

D. How many bed-hold days during this year were paid by Public Aid?
65 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 06/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 60 and days of care provided 2,870

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 10/31/2004 Fiscal Year: 10/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	132,072	19,427	5,615	157,114		157,114	(363)	156,751			1
2	Food Purchase		120,576		120,576		120,576	(11,897)	108,679			2
3	Housekeeping	92,268	9,091		101,359		101,359	(598)	100,761			3
4	Laundry	30,930	15,534		46,464		46,464		46,464			4
5	Heat and Other Utilities			64,132	64,132		64,132	(15,945)	48,187			5
6	Maintenance	58,991	19,675	29,110	107,776		107,776	(799)	106,977			6
7	Other (specify):*			2,470	2,470		2,470	(2,470)				7
8	**TOTAL General Services**	314,261	184,303	101,327	599,891		599,891	(32,072)	567,819			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	935,427	55,208	3,015	993,650		993,650		993,650			10
10a	Therapy		328	202,874	203,202		203,202		203,202			10a
11	Activities	42,788	2,024	2,535	47,347		47,347		47,347			11
12	Social Services	47,966	236	2,793	50,995		50,995		50,995			12
13	Nurse Aide Training											13
14	Program Transportation			8,241	8,241		8,241		8,241			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,026,181	57,796	224,258	1,308,235		1,308,235		1,308,235			16
	C. General Administration											
17	Administrative	67,459			67,459		67,459		67,459			17
18	Directors Fees			10,800	10,800		10,800		10,800			18
19	Professional Services			19,885	19,885		19,885		19,885			19
20	Dues, Fees, Subscriptions & Promotions			19,469	19,469		19,469	(10,640)	8,829			20
21	Clerical & General Office Expenses	53,420	9,109	31,322	93,851		93,851		93,851			21
22	Employee Benefits & Payroll Taxes			337,509	337,509		337,509		337,509			22
23	Inservice Training & Education			2,812	2,812		2,812		2,812			23
24	Travel and Seminar			5,144	5,144		5,144		5,144			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			65,552	65,552		65,552		65,552			26
27	Other (specify):*											27
28	**TOTAL General Administration**	120,879	9,109	492,493	622,481		622,481	(10,640)	611,841			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,461,321	251,208	818,078	2,530,607		2,530,607	(42,712)	2,487,895			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Greenbrier Lodge #0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			81,619	81,619		81,619	(35,940)	45,679			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,322	9,322		9,322	(6,158)	3,164			32
33	Real Estate Taxes			49,998	49,998		49,998	(14,833)	35,165			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,370	4,370		4,370		4,370			35
36	Other (specify):*											36
37	**TOTAL Ownership**			145,309	145,309		145,309	(56,931)	88,378			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14,614	103,097	117,711		117,711		117,711			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,350	33,350		33,350		33,350			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		14,614	136,447	151,061		151,061		151,061			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,461,321	265,822	1,099,834	2,826,977		2,826,977	(99,643)	2,727,334			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,857)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	147	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,646)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(89,287)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (99,643)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (99,643)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Greenbrier Lodge

ID# 0044487

Report Period Beginning: 11/01/2003

Ending: 10/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Apartment - Dietary Supplies	$ (363)	1	1
2	Apartment - Food Cost	(11,897)	2	2
3	Apartment - Housekeeping Supplies	(598)	3	3
4	Apartment - Utilities	(13,088)	5	4
5	Aparment - Building Supplies	(112)	6	5
6	Apartment - Repairs/Maintenance	(687)	6	6
7	Apartment - Lifeline	(2,470)	7	7
8	Apartment - Advertising	(2,994)	20	8
9	Apartment - Mortgage Interest	(6,158)	32	9
10	Apartment - Real Estate Tax	(14,833)	33	10
11	Apartment - Depreciation	(36,087)	30	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(89,287)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenbrier Lodge # 0044487 **Report Period Beginning:** 11/01/2003 **Ending:** 10/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(363)	0	0	0	0	0	0	0	0	0	0	(363)	1
2	Food Purchase	(11,897)	0	0	0	0	0	0	0	0	0	0	(11,897)	2
3	Housekeeping	(598)	0	0	0	0	0	0	0	0	0	0	(598)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(15,945)	0	0	0	0	0	0	0	0	0	0	(15,945)	5
6	Maintenance	(799)	0	0	0	0	0	0	0	0	0	0	(799)	6
7	Other (specify):*	(2,470)	0	0	0	0	0	0	0	0	0	0	(2,470)	7
8	**TOTAL General Services**	(32,072)	0	0	0	0	0	0	0	0	0	0	(32,072)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(10,640)	0	0	0	0	0	0	0	0	0	0	(10,640)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,640)	0	0	0	0	0	0	0	0	0	0	(10,640)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,712)	0	0	0	0	0	0	0	0	0	0	(42,712)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenbrier Lodge # 0044487 **Report Period Beginning:** 11/01/2003 **Ending:** 10/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(35,940)	0	0	0	0	0	0	0	0	0	0	(35,940)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,158)	0	0	0	0	0	0	0	0	0	0	(6,158)	32
33	Real Estate Taxes	(14,833)	0	0	0	0	0	0	0	0	0	0	(14,833)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(56,931)	0	0	0	0	0	0	0	0	0	0	(56,931)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(99,643)	0	0	0	0	0	0	0	0	0	0	(99,643)	45

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Greenbrier Lodge, Inc.
Attachment to Schedule VII - Related Parties
10/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS			Directors Fees, Line 18		
Name	Ownership %				
Margery Arends	$4,000	7.41%			
Della M Bork, Trustee	2,000	3.70%			
Harold F Bork Estate	2,000	3.70%			
Ronald D Bork	4,000	7.41%	600		
Mary K Brown, Trustee	2,000	3.70%			
Betty Cook	2,000	3.70%			
Eugene Doran	2,000	3.70%			
Shirley Freeman	2,000	3.70%			
Robert Frerichs	4,000	7.41%			
Ray Froelich	2,000	3.70%			
Ruth Hanna	2,000	3.70%			
Charles Kerchenfaut	2,000	3.70%			
Marilyn Kerchenfaut	2,000	3.70%	2,400		
Robert Kurtenbach	4,000	7.41%			
Dr Hugh McIntosh Trust	2,000	3.70%			
Gladys McMillan Estate	2,000	3.70%			
Darla Propes	2,000	3.70%			
Jerome Rebholz	2,000	3.70%	2,400		
Johanna C. Somers, Trustee	4,000	7.41%	2,400		
Edith Stuckey	2,000	3.70%			
James D Stuckey	4,000	7.41%	450		
Robert King	0	0.00%			
Janet Livengood	0	0.00%	750		
Jeff McMillan	0	0.00%	600		
Jeff Orr	0	0.00%	600		
Bob King	0	0.00%	600		
	$ 54,000	100.00%	10,800	0	0

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See schedule of owners for directors fees								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 0/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Vermillion Valley Bank		x	Working Capital	$2,214.31	04/30/02	Line of Credit		08/09/08		3,164	6
7												7
8												8
9	TOTAL Facility Related				$2,214.31		$	$			$ 3,164	9
	B. Non-Facility Related*											
10	Vermillion Valley Bank		x	Apartment Mortgage	$2,509.96	07/21/03	137,286	76,565	10/09/08		6,158	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$2,509.96		$ 137,286	$ 76,565			$ 6,158	14
15	TOTALS (line 9+line14)						$ 137,286	$ 76,565			$ 9,322	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 29,480	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 35,284	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,804	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 29,361	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 35,165	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	34,320	8
	2000	35,331	9
	2001	35,376	10
	2002	35,170	11
	2003	35,284	12

Tax paid in 2004 for 2003 = $35,284 (difference to 2004 immaterial)

35,284/ 12 months X 10 months accrual (through 10/31/04) = 29,403 (used 29,361, diff. Immaterial)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenbrier Lodge COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0044487

CONTACT PERSON REGARDING THIS REPORT Teresa Thompson

TELEPHONE (815) 686-2277 FAX #: (815) 686-2812

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-04-03-300-003	Nursing Home	$ 35,284.00	$ 35,284.00
2.	04-04-03-302-001	Apartments	$ 15,112.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.	Real estate taxes are billed separately		$	$
8.	for the Nursing Home and the		$	$
9.	apartments, Therefore, no cost		$	$
10.	allocation is required.		$	$
		TOTALS	$ 50,396.00	$ 35,284.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? x YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,804 B. General Construction Type: Exterior Brick Frame Protected Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Completely separate building and lot.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	228,690	1972	$ 22,181	1
2					2
3	TOTALS	228,690		$ 22,181	3

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1972	1972	$ 519,786	$ 14,851	35	$ 14,851	$	$ 471,506	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fully Depreciated				44,845					44,845	9
10											10
11	Building Improvements			1995	78,510	2,013	39	2,013		18,705	11
12	Land Improvements			1995	21,490	1,319	15	1,433	114	12,994	12
13	Septic System			1997	18,954	1,168	15	1,264	96	8,846	13
14	Drainage Improvement			1998	5,561	333	15	371	38	2,349	14
15	Sprinkler System			1998	14,144	514	27.5	514		3,257	15
16	Landscaping			1999	19,119	1,315	15	1,275	(40)	6,207	16
17	Floor Tiling			1997	3,255	201	15	217	16	1,555	17
18	Wall Protectors			2002	3,730	533	15	248	(285)	685	18
19	Fire Door			2004	1,702	36	39	36		36	19
20	Aluminum Roof Coating			2004	4,485	19	39	19		19	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 735,581	$ 22,302		$ 22,241	$ (61)	$ 571,004	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 87,887	$ 16,306	$ 16,513	$ 207		$ 60,468	71
72	Current Year Purchases	13,612	1,375	1,375			1,375	72
73	Fully Depreciated Assets	91,604					91,604	73
74								74
75	TOTALS	$ 193,103	$ 17,681	$ 17,888	$ 207		$ 153,447	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	1999 Dodge Van	2001	$ 27,750	$ 5,550	$ 5,550	$	5	$ 15,724	76
77										77
78										78
79										79
80	TOTALS			$ 27,750	$ 5,550	$ 5,550	$		$ 15,724	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 978,615	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,533	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,679	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 146	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 740,175	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment Building & Equipment	$ 834,522	$ 36,087	$ 249,498	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 834,522	$ 36,087	$ 249,498	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Greenbrier Lodge STATE OF ILLINOIS # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts	63,685					63,685	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39.3							39,361	13
14	TOTAL			$ 63,685		$	$		$ 103,046	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Greenbrier Lodge, Inc.
Period ended 10/31/2004
ID # 0044487

Attachment to Schedule XIV, Line 13

Description		Amount
IV Therapy Supplies		4,011
Air Fluidized Therapy/Oxyge		17,614
Radiology		1,685
Contracted Lab		11,032
Oxygen Supplies		5,019
Total	$	39,361

STATE OF ILLINOIS

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 10/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 114,722	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	394,257		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	22,301		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 531,280	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,181		13
14	Buildings, at Historical Cost	1,440,044		14
15	Leasehold Improvements, at Historical Cost	11,059		15
16	Equipment, at Historical Cost	339,856		16
17	Accumulated Depreciation (book methods)	(1,002,434)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 810,706	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,341,986	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 46,873	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,584		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,996		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Expenses	8,282		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 160,735	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	76,565		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 76,565	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 237,300	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,104,686	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,341,986	$	48

*(See instructions.)

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,111,585	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,111,585	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	6,601	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(13,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (6,899)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,104,686	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,641,275	1
2	Discounts and Allowances for all Levels	(562,849)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,078,426	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	402,118	6
7	Oxygen	25,018	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 427,136	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	125,557	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,728	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 147,285	23
	D. Non-Operating Revenue		
24	Contributions	1,630	24
25	Interest and Other Investment Income***	1,614	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,244	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Apartment Rents	173,199	28
28a	Guest Meals	94	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 173,293	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,829,384	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	599,891	31
32	Health Care	1,304,647	32
33	General Administration	626,069	33
	B. Capital Expense		
34	Ownership	145,309	34
	C. Ancillary Expense		
35	Special Cost Centers	117,711	35
36	Provider Participation Fee	33,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,826,977	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,407	41
42	**Income Taxes**	4,194	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 6,601	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Greenbrier Lodge, Inc.
Period Ended 10/31/2004
ID# 0044487

Reconciliation of book income to Federal Tax Income: Federal Tax return is on cash basis

Income per cost report:	2,407
Reversal of 10/31/03 book/tax difference	202,723
Income reduction due to removal of Accounts Receivable	(394,257)
Income reduction due to removal of Other Deferred Costs	(18,060)
Increase in income due to removal of Accounts Payable	46,871
Increase in income due to removal of Other Accrued Expenses	112,250
Income before taxes	(48,066)
Book income per Federal Tax Return	(48,066)

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,832	4,291	$ 106,022	$ 24.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,735	6,422	125,504	19.54	3
4	Licensed Practical Nurses	9,594	10,744	204,074	18.99	4
5	Nurse Aides & Orderlies	41,651	46,644	443,390	9.51	5
6	Nurse Aide Trainees	184	206	1,639	7.96	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,885	6,590	75,575	11.47	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	1,976	2,213	26,400	11.93	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,904	15,571	119,941	7.70	15
16	Dishwashers					16
17	Maintenance Workers	5,313	5,950	65,849	11.07	17
18	Housekeepers	11,547	12,931	102,091	7.90	18
19	Laundry	4,618	5,172	34,464	6.66	19
20	Administrator	1,800	2,016	72,266	35.85	20
21	Assistant Administrator	50	56	835	14.91	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,076	4,565	61,692	13.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,868	2,092	21,579	10.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,033	125,463	$ 1,461,321 *	$ 11.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,615	1.3	35
36	Medical Director		4,800	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,535	11.3	44
45	Social Service Consultant		2,793	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,743		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theresa Thompson	Administrator	0	$ 67,459
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,459

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Smith Koelling Dykstra & Ohm	Accounting Services	$ 12,850
Sylvia J. Boecker, PC	Legal Fees	835
Richard Peelo & Assoc	Cost Report	6,200
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 19,885

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,649
Unemployment Compensation Insurance	30,611
FICA Taxes	108,224
Employee Health Insurance	126,132
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Incentives	9,893
TOTAL (agree to Schedule V, line 22, col.8)	$ 337,509

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,951
Health Care Worker Background Check	332
(Indicate # of checks performed 24)	
Professional Dues & Licenses	5,546
Public Relations Expense	7,646
Advertising	2,994
Less: Public Relations Expense	(7,646)
Non-allowable advertising	(2,994)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,829

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,144
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,144

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Greenbrier Lodge # 0044487 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,564** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **33,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Greenbrier Lodge
0044487
10/31/2003

Attachment to Schedule V, Line 24

Date	Attendee	Job Title	Amount	Location	Seminar Title	Seminar Sponsor
August 18& 19, 2004	Terri Thompson	Administrator	580	Bloomington, IL	Res Abuse Facility Comp	INHAA
Sept 13 - 15, 2004	Terri Thompson Amy Aquino Michelle Clifton	Administrator DON ADON	2336	Springfield, IL	IL Healthcare Conv & Trade Show	IHCA
March 10, 2004	Amy Aquino Michelle Clifton Cyra Wahls	DON ADON ADON	827	Springfield	IHCA various	IHCA
Mar 29,30, 2004	Terri Thompson	Administrator	851	Springfield, IL	INHAA Trade Show	INHAA
Nov 10,2003	Terri Thompson	Administrator	550	Peoria, IL	MDS Reimbursement Conflict Resolution	INHAA
			5144			

Greenbrier Lodge
004487
10/31/2004

Attachment to Page 23, Question 13

The apartments are housed in a totally separate building with all related expenses classified separately in the chart of accounts